2020 Annual Report

Fiscal Year 2020: October 1, 2019 – September 30, 2020

Maternal and Infant Community Health Collaborative (MICHC) Initiative

An Overview

The 2020 MICHC Annual Report summarizes New York State's (NYS) continued efforts to improve maternal and infant health outcomes for high-need, low-income women and their families while reducing persistent racial, ethnic, and economic disparities in those outcomes.

Outcomes are broadly categorized as follows:

- ❖ Services Provided by Lifecourse Phase
- ❖ Referrals to Healthcare and Family Social Support
- ❖ Outreach and Engagement
- ❖ COVID-19 Impact Analysis

This report presents summary statistics based on data obtained from participating MICHC programs that utilize Community Health Workers (CHWs). The data represents clients served and services rendered by CHWs in federal FY2020. Data were obtained quarterly from individual MICHC programs.

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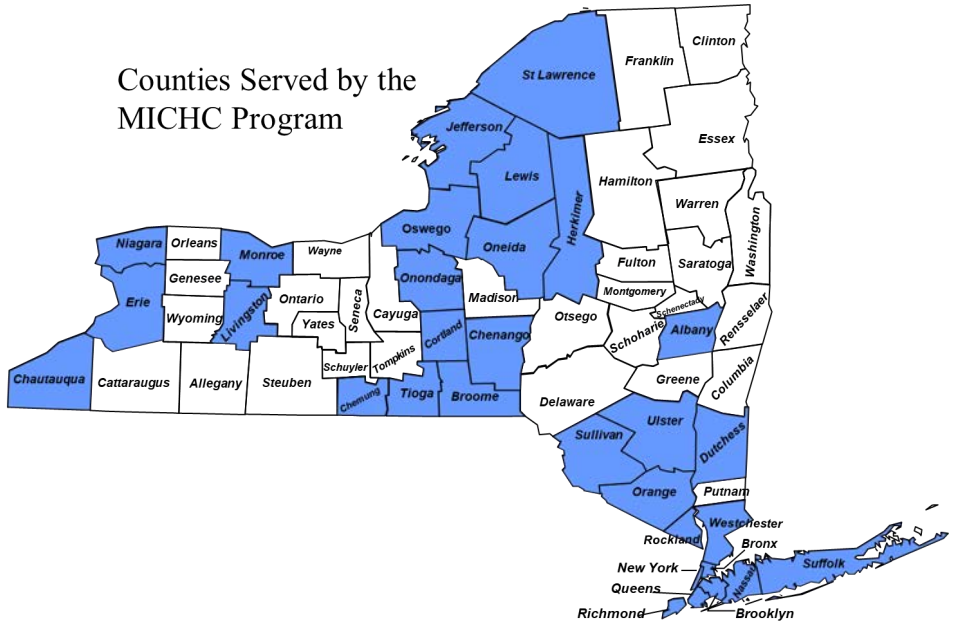
About MICHC

The MICHC initiative seeks to improve maternal and infant health outcomes through the development of multi-dimensional community systems of integrated and coordinated programs and services designed to address maternal and infant health behaviors and ensure support and service systems across the reproductive life course. The MICHC programs utilize CHWs to assist high-need, low-income women of reproductive age and their families with accessing continuous quality healthcare and other needed community support services. MICHC supports 23 programs in 31 counties across New York State.



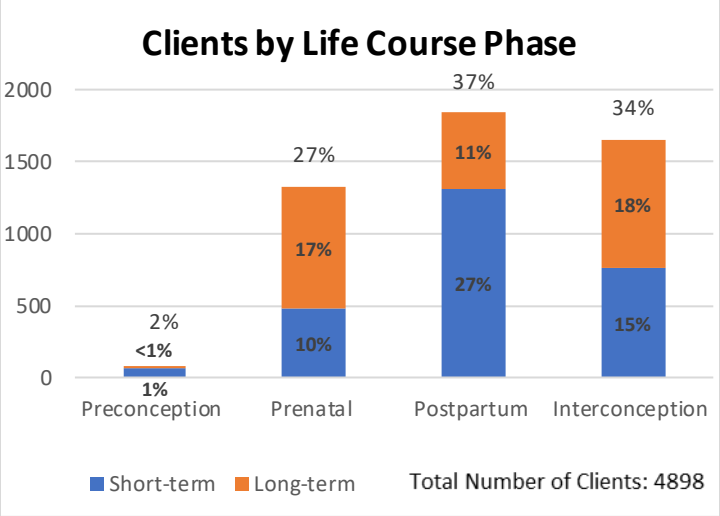
MICHC programs conduct outreach to engage and serve eligible clients and provide them with essential services. In 2020, the MICHC programs across New York served **4,898 clients**. There were **17,599 home and virtual visits** conducted by CHWs during the year, and these resulted in **22,565 referrals issued and 16,323 referrals completed**.

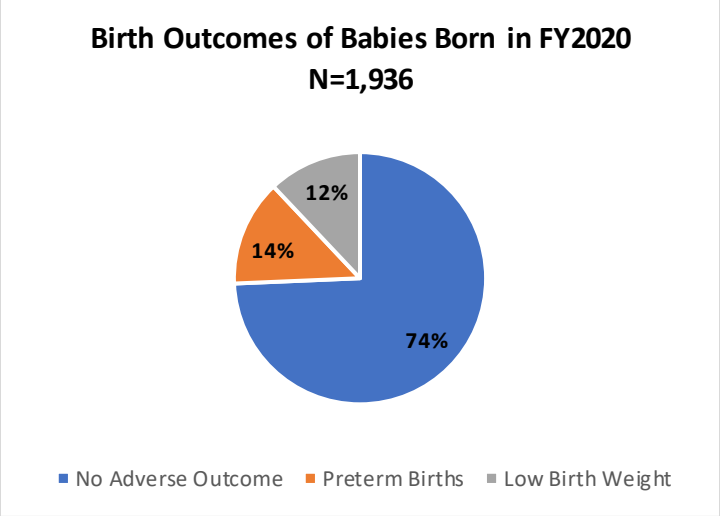
FY2020 Report Highlights

- **Clients utilizing MICHC services**
- **Service breakdown by Life Course Phase**
- **Services most utilized by MICHC clients**
- **Program Encounter and Outreach Analysis**
- **Covid-19 pandemic's impact on services**

New York State Clients Utilizing MICHC in 2020

CHWs assist low resourced families with accessing and navigating healthcare and other essential support services, conduct in-home and virtual visits, and provide group and individual education. This section provides a demographic overview of MICHC clients in FY2020.

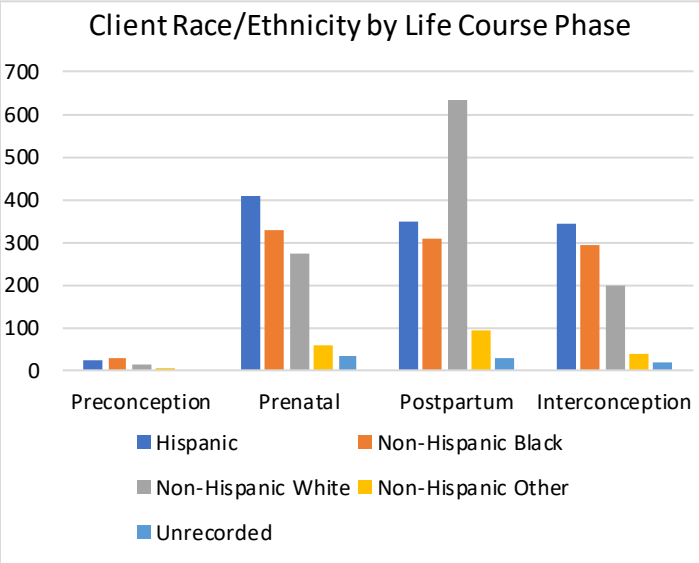


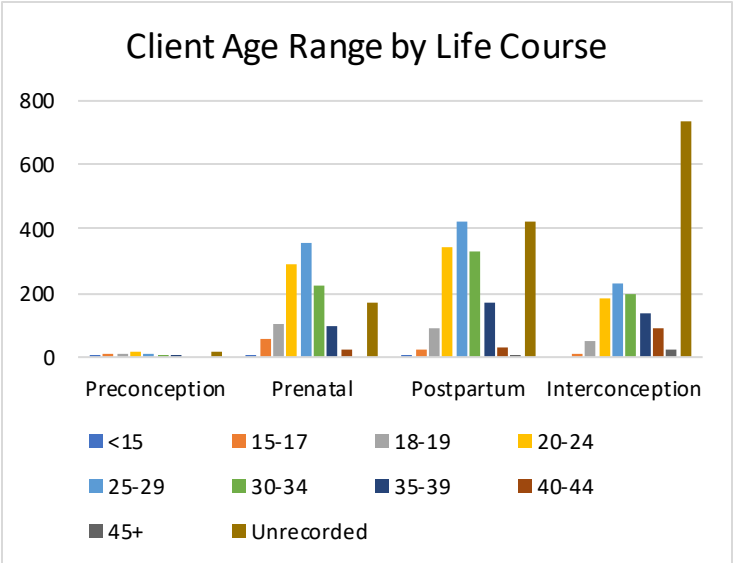


Clients by Race/Ethnicity		
Race/Ethnicity	Number of Clients	Percent
Hispanic	1,117	23%
Non-Hispanic Black	957	20%
Non-Hispanic White	1,118	23%
Non-Hispanic Other	188	4%
Unrecorded	1,518	31%
Total	4,898	100%

Clients by Age Range		
Age Range	Total	Percent
<15	13	0%
15-17	104	2%
18-19	254	5%
20-24	835	17%
25-29	1,025	21%
30-34	754	15%
35-39	400	8%
40-44	147	3%
45+	25	1%
Unrecorded	1,341	27%
Total	4,898	100%

Birth Outcome Statistics	
Birth Outcome	Total
Infants Born	1,936
Preterm Births	264
Low Birth Weight Births	233
First Births	623

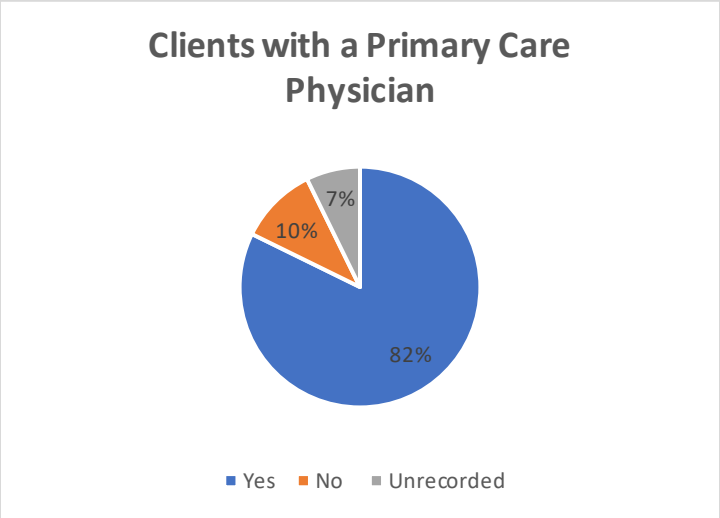


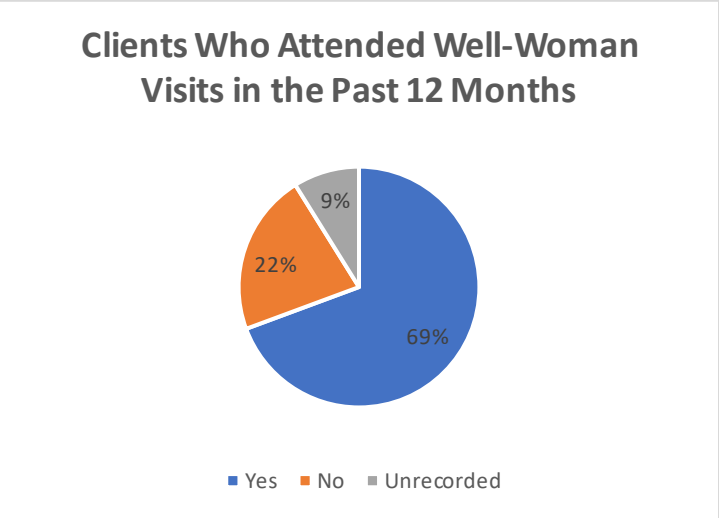


Service Delivery by Life Course Phase

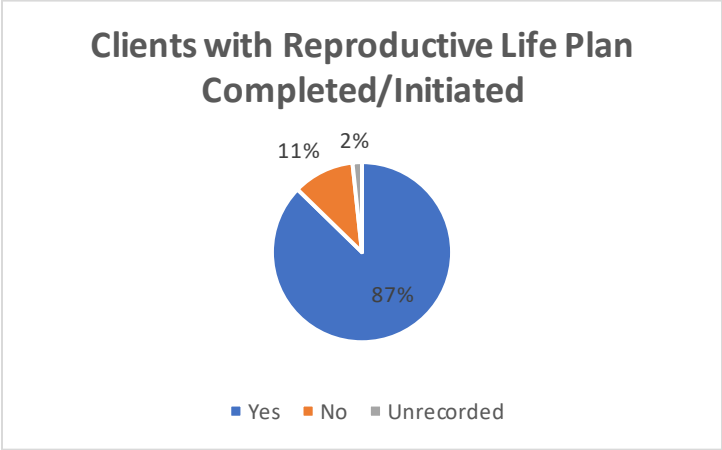
❖ Preconception Clients

The information displayed below summarizes MICHC service data for the 81 clients in the "preconception" life course phase. Clients in this phase are those of child-bearing age who have not given birth before, but are looking to become pregnant. This information provides an overview of which services these clients have utilized and what appointments they have attended. Clients may be screened multiple times during their participation in the MICHC program.





Client Health Insurance Status	
Health Insurance Type	**Percent**
Medicaid	76%
Other or Unrecorded	24%



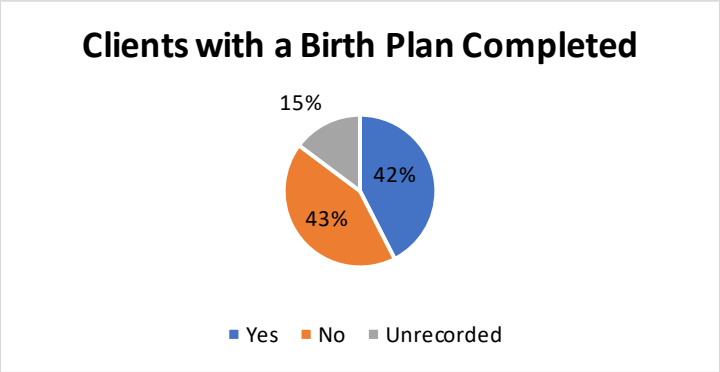
	Screenings	Referrals	Referrals Completed	
Client Screening Type	**Number**	**Number**	**Number**	**Percent**
Alcohol	69	0	0	0%
Ages and Stages Questionnaire	57	0	0	0%
Depression	51	22	10	45%
Domestic Violence	67	1	1	100%
Health Insurance	64	1	1	100%
Substance Abuse	64	0	0	0%
Oral Health	65	15	6	40%
Smoking	62	4	0	0%
Total	499	43	18	42%

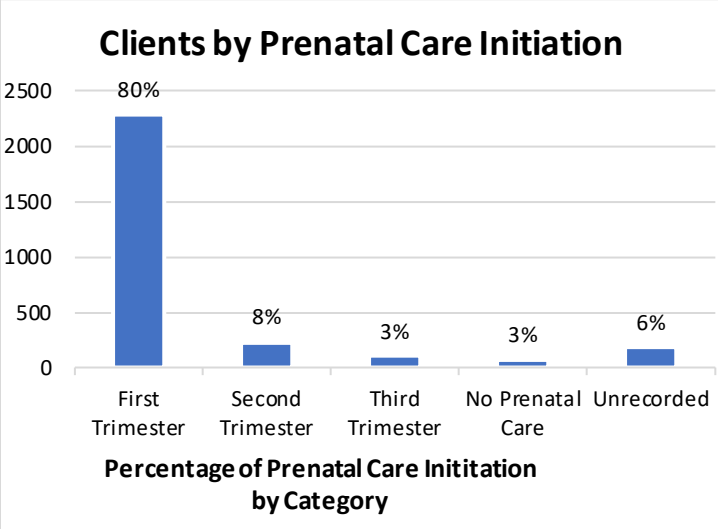
❖ Prenatal/Postpartum Clients

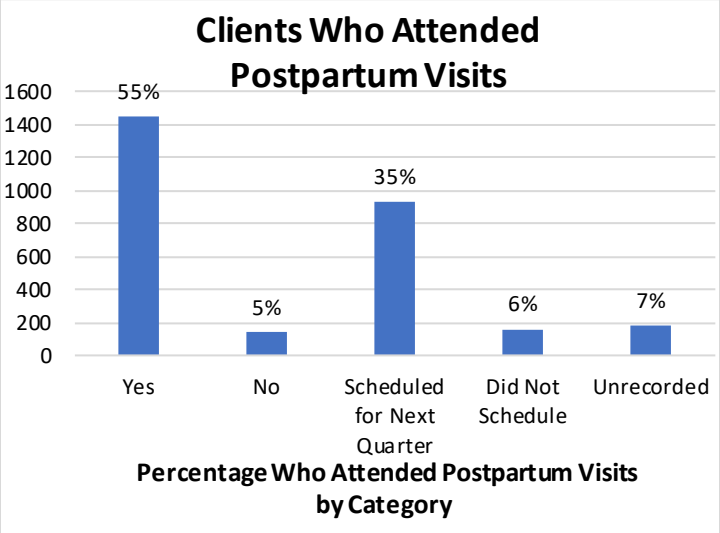
The information displayed below summarizes MICHC service data for the clients in either the "prenatal" (N=1,324) or "postpartum" (N=1,836) life course phase. Clients in the "prenatal" phase were pregnant at the end of the reporting period, while those in the "postpartum" phase had given birth during the reporting period. This information provides an overview of which services these clients have utilized and what appointments they attended.

Clients may be screened multiple times during their participation in the MICHC program.

Client Health Insurance Status	
Health Insurance Type	**Percent**
Medicaid	92%
Private Insurance	3%
FPBP/FPEP	0%
Uninsured	1%
Ineligible	1%
Other	1%
Unrecorded	1%





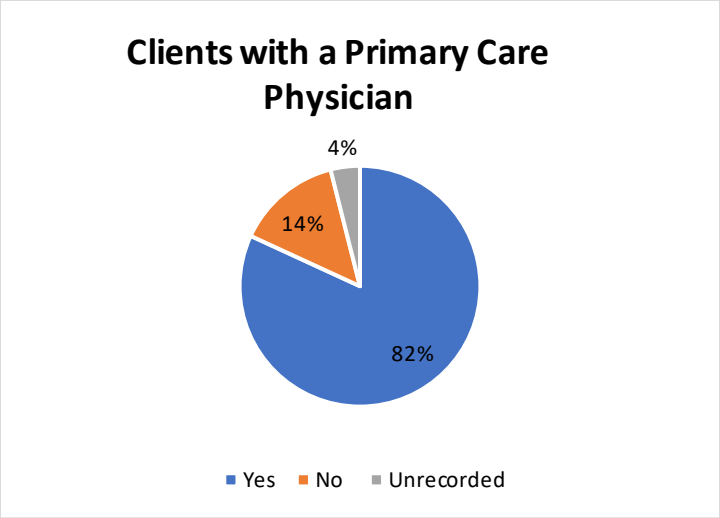


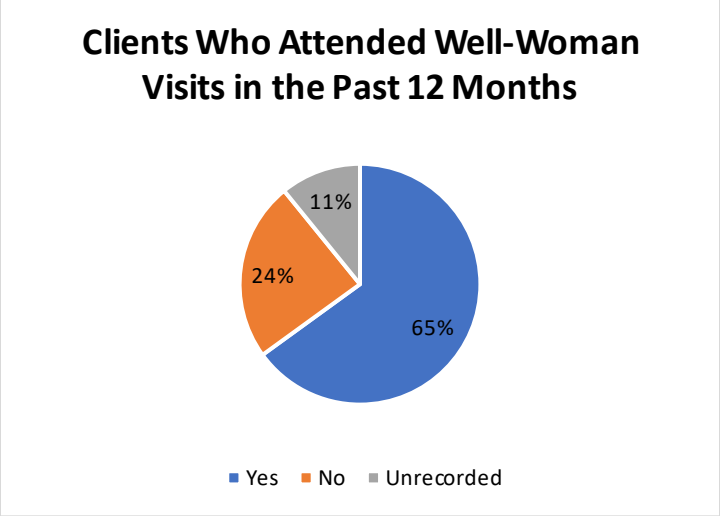
	Screenings	Referrals	Referrals Completed	
Screening Type	**Number**	**Number**	**Number**	**Percent**
Alcohol	1,363	11	8	73%
Ages and Stages Questionnaire	125	28	13	46%
Depression	1,353	366	197	54%
Domestic Violence	1,373	101	63	62%
Health Insurance	1,629	207	165	80%
Substance Abuse	1,429	11	8	73%
Oral Health	1,222	322	148	46%
Smoking	1,440	51	36	71%
Total	9,934	1,097	638	58%

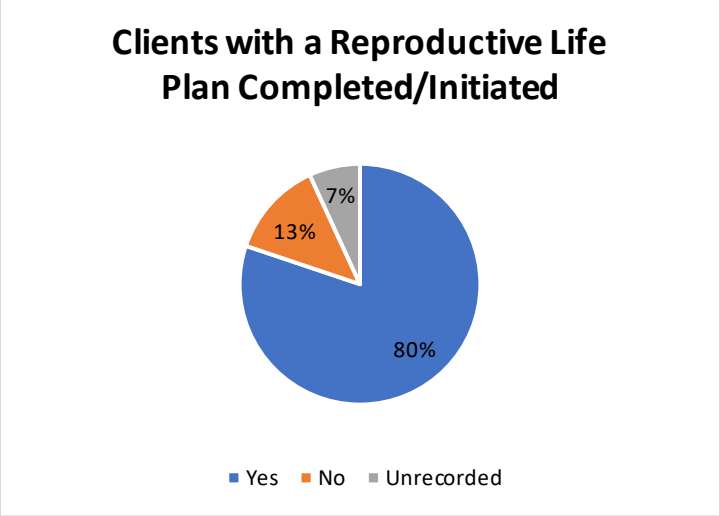
❖ Interconception Clients

The information displayed below summarizes MICHC service data for the 1,657 clients in the "interconception" life course phase. Clients in this phase have given birth before but are not currently pregnant. This information provides an overview of which services these clients have utilized and what appointments they have attended. Clients may be screened multiple times during their participation in the MICHC program.

Client Health Insurance Status	
Health Insurance Type	**Percent**
Medicaid	85%
Private Insurance	3%
Medicare/ SSI	1%
FPBP/FPEP	0%
Uninsured	2%
Ineligible	5%
Other	1%
Unrecorded	3%





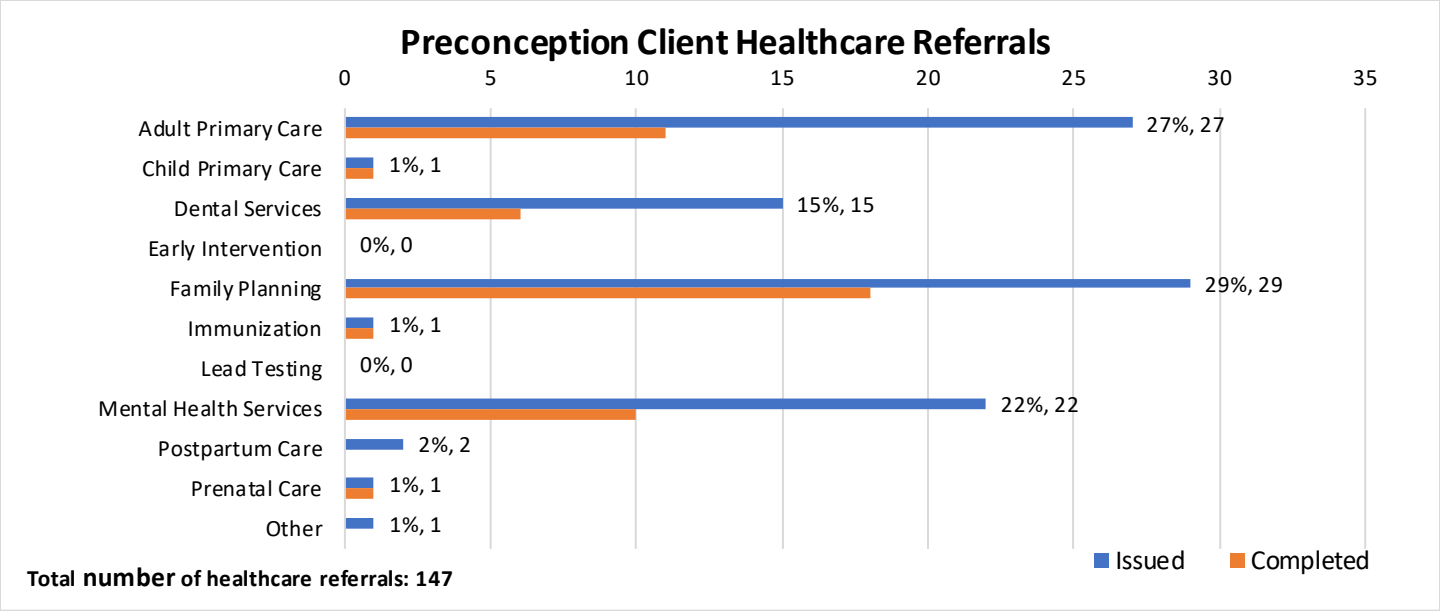


	Screenings	Referrals	Referrals Completed	
Screening Type	**Number**	**Number**	**Number**	**Percent**
Alcohol	1,659	25	24	96%
Ages and Stages Questionnaire	827	120	83	69%
Depression	1,716	478	263	55%
Domestic Violence	1,682	120	78	65%
Health Insurance	2,107	233	182	78%
Substance Abuse	1,684	25	24	96%
Oral Health	1,708	385	205	53%
Smoking	1,759	36	14	39%
Total	13,142	1,422	873	61%

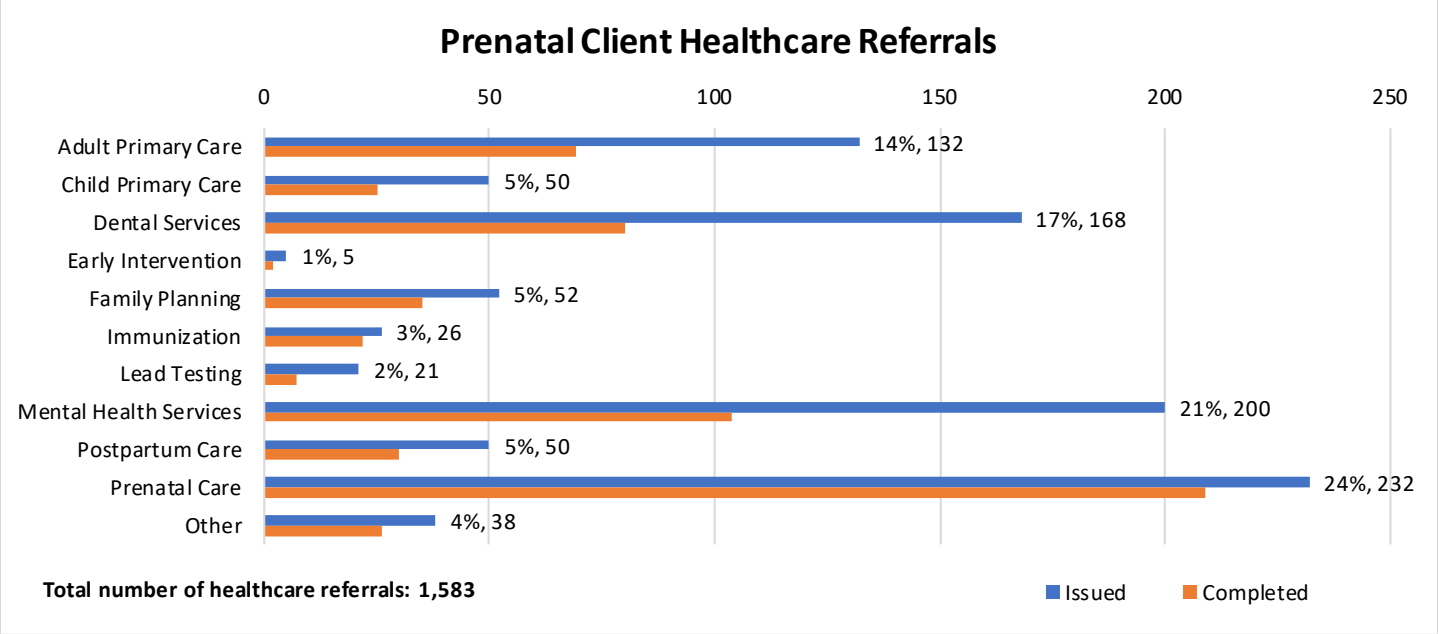
Referrals to Services

❖ Healthcare Referrals

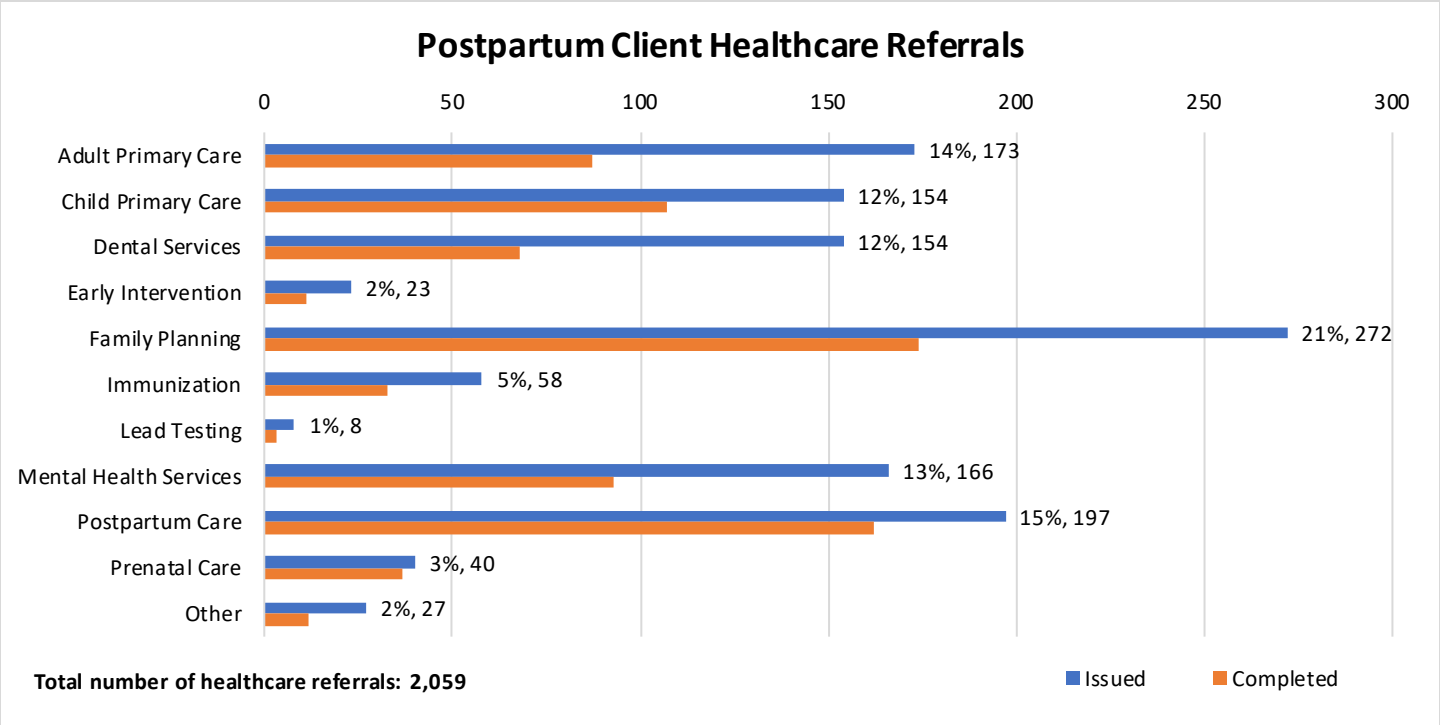
Healthcare referrals are an essential part of MICHC services for connecting clients and their families to care. This section showcases the referrals given to clients for various healthcare services in their community. The blue bar represents the number of clients referred during the reporting period and is labelled with the percentage of all healthcare referrals in this category followed by the total number of referrals in the category by life course phase. The orange bar represents the number of the referrals completed by clients engaging with the service. Adult primary care, family planning, and mental health services were the top healthcare referrals for preconception clients.



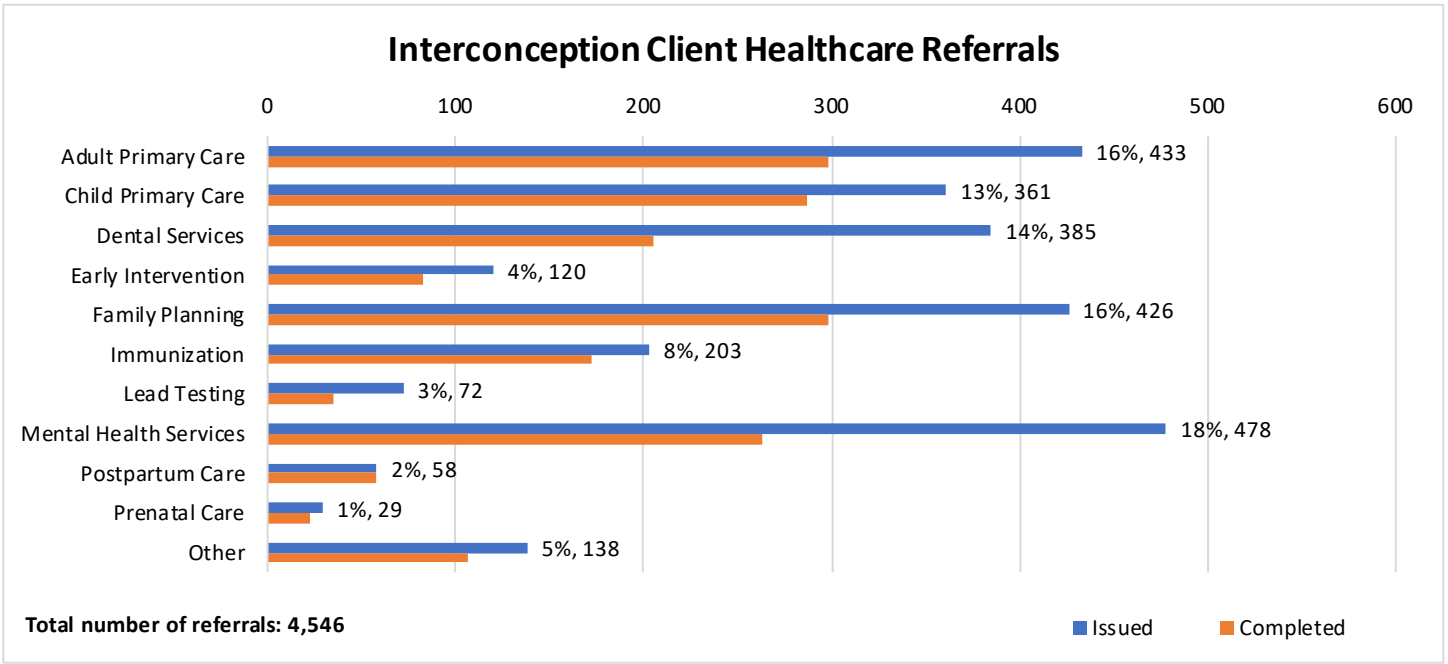
The top healthcare referral for prenatal clients was connecting clients to a prenatal care provider; 90% of prenatal clients referred to prenatal care engaged in care. Other top healthcare referrals for prenatal clients included mental health services, dental services, and adult primary care.



For postpartum clients, family planning services, postpartum care, adult primary care, mental health services, child primary care, and dental services were the top healthcare referrals.



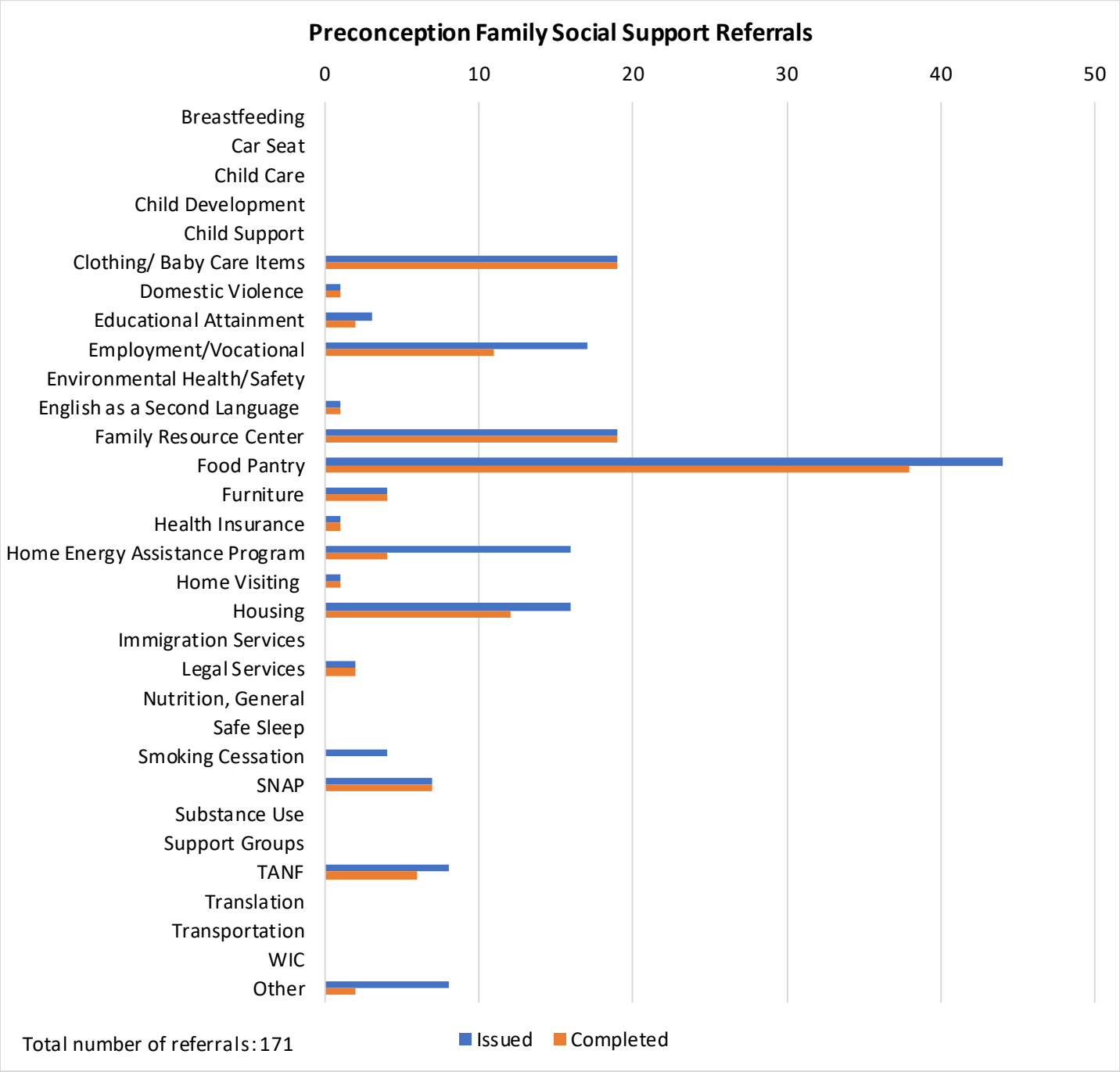
The highest proportions of healthcare referrals for interconception clients were mental health services, family planning serivces, adult primary care, dental services, and child primary care.



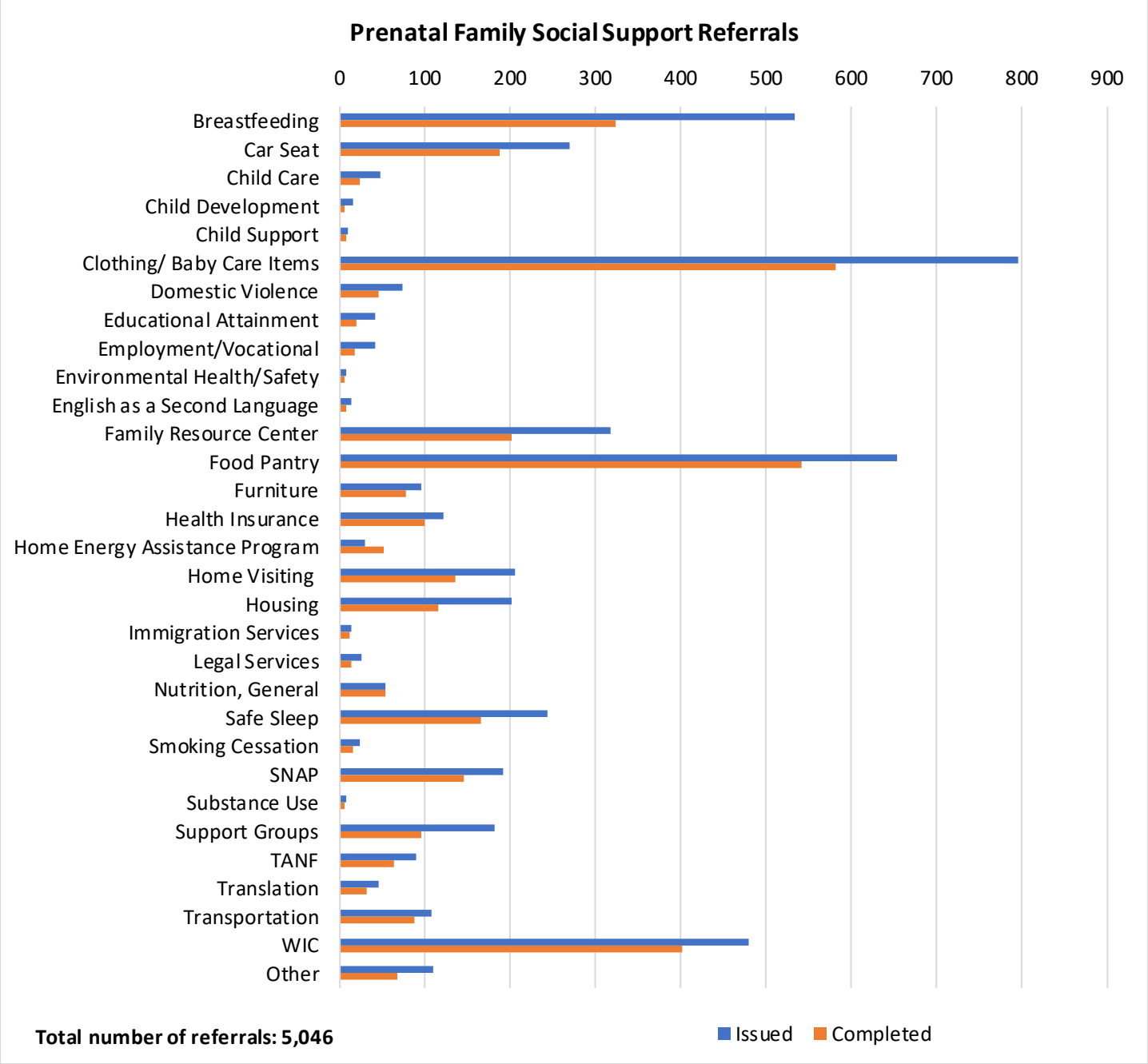
The top healthcare referrals across all life course phases were mental health services and connections to healthcare providers for primary care and family planning, followed by dental providers.

❖ Family Social Support Referrals

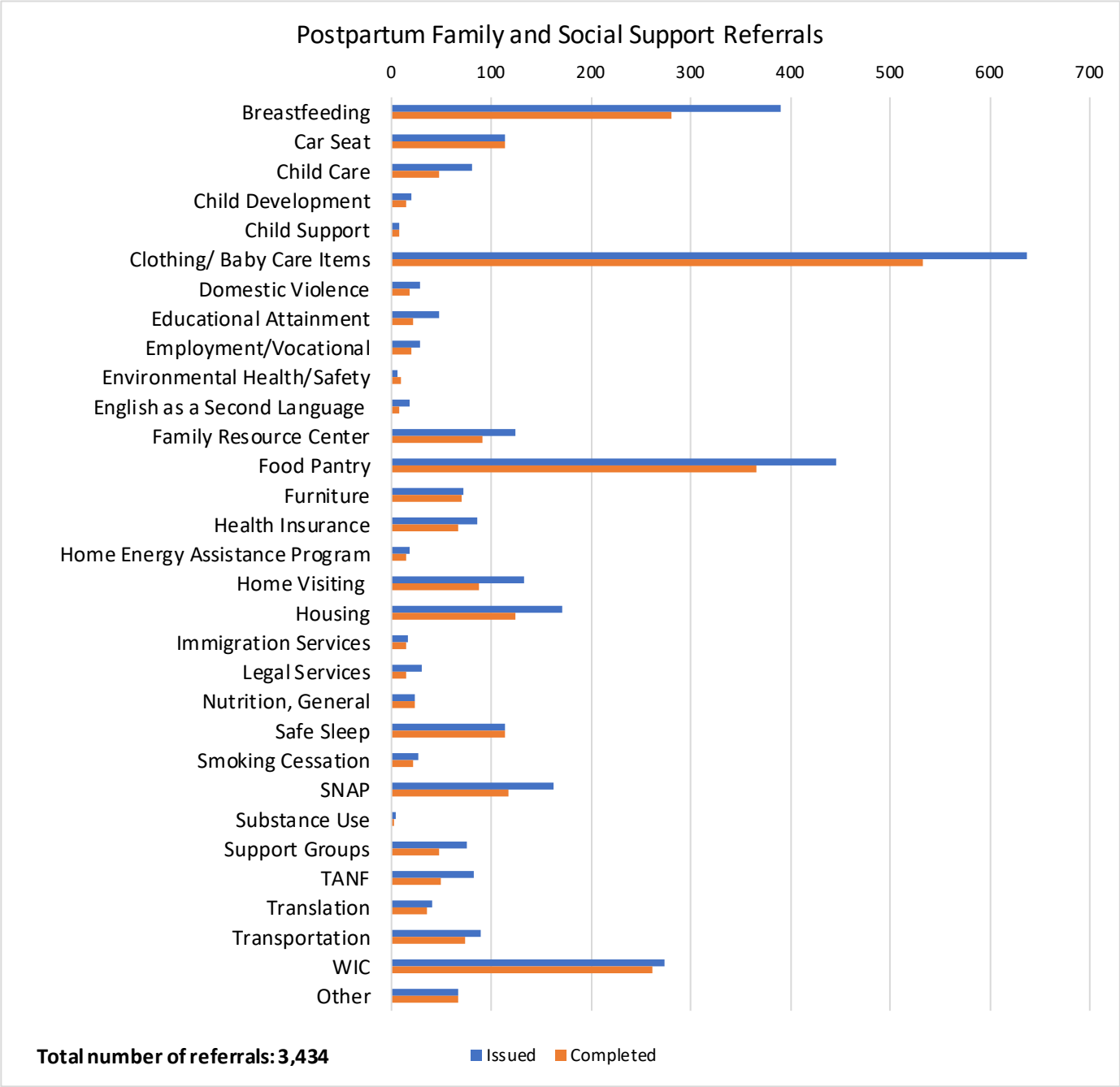
Family Social Support referrals are an essential part of MICHC services for connecting clients and their families to appropriate services and care. This section showcases the referrals given to clients for various Family and Social Support services in their community. The blue bar is the number of clients referred to the service during the year; the orange bar is the number of referrals issued that were completed. SNAP is the Supplemental Nutritional Assistance Program, TANF is the Temporary Assistance for Needy Families, and WIC is the Special Supplemental Nutritional Assistance Program for Women, Infants, and Children. The greatest need for preconception clients was concrete supports including food pantry, clothing, and baby care items.



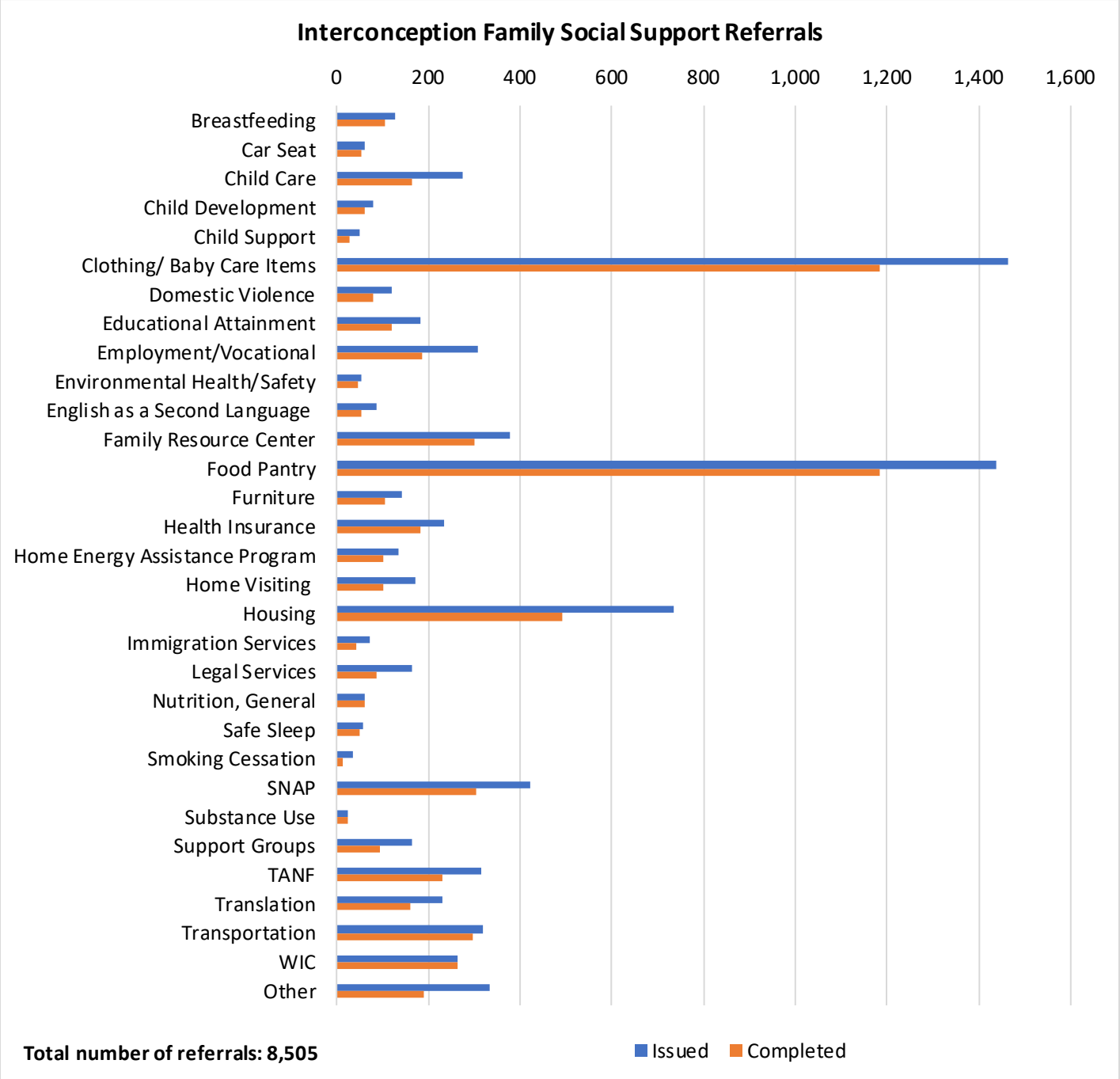
The greatest needs for prenatal clients were also concrete supports including food pantry, clothing, baby care items, followed by breastfeeding support and WIC. More than 500 prenatal clients were connected to food pantries and clothing and care items, 400 were connected to WIC, and over 300 were connected to breastfeeding supports during the year.



Family social support referrals for postpartum clients mirrored the needs of prenatal clients. At least 100 postpartum clients also obtained car seats, were connected to housing, received safe sleep products, and were connected to SNAP benefits through referrals to MICHC community partners.

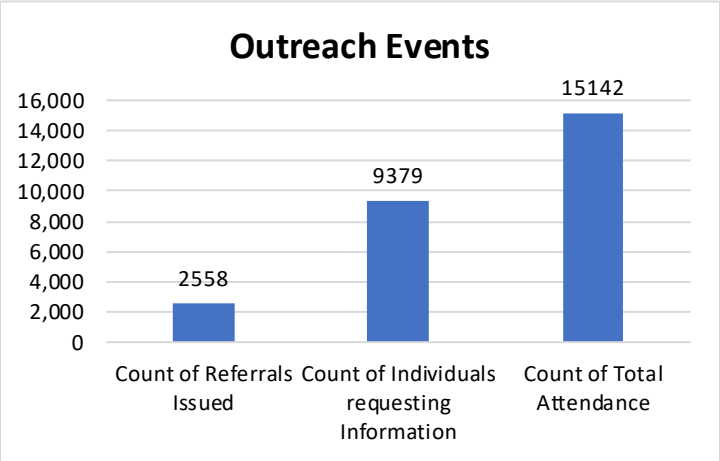


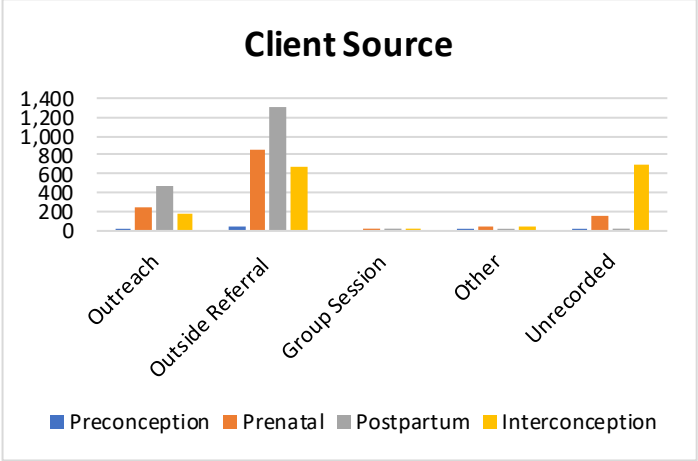
The top family social support referrals for interconception clients were for food pantries and clothing and baby care items with 1,183 and 1,182 completed referrals respectively. The completed referrals for housing services (491), SNAP benefits (304), family resource center (301), transportation (297), WIC (265), and TANF (229) demonstrate throughout the life course the MICHC programs' ability to connect clients and families to needed concrete services and supports.



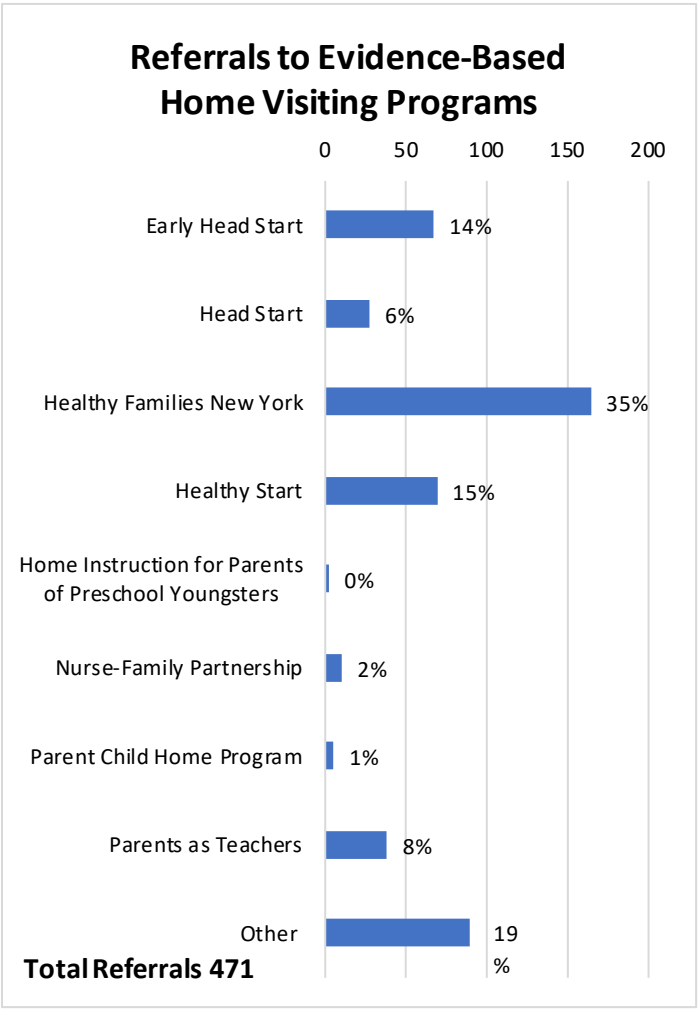
❖ Outreach and Engagement

MICHC programs engage clients in the community through door-to-door outreach, group education classes, and through various partnerships with other community-based organizations. During outreach, CHWs may provide information, education, and referrals to services. Clients are engaged and enrolled in the program through direct community outreach or through outside referrals to MICHC from a network of community partners. Clients can also be referred to evidence-based home visiting programs as appropriate to their needs. This section provides an overview of outreach efforts in FY2020.



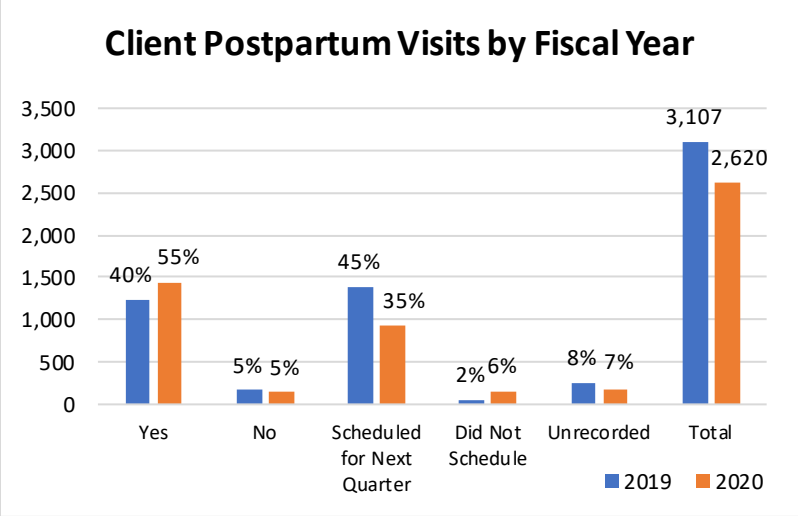


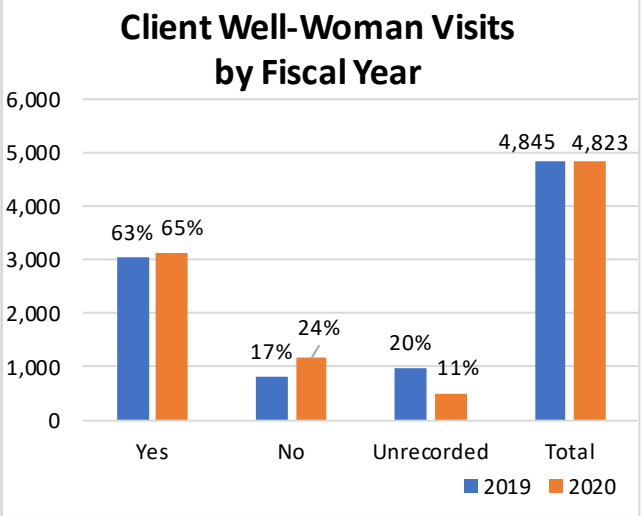
Outside Referrals to MICHC		
Source of Encounters	**Clients**	**Percent**
Outside referrals to MICHC programs	2,963	68.0%
Birthing Hospital	1,039	35.1%
Prenatal Care Provider	442	14.9%
WIC	250	8.4%
Self	244	8.2%
Community-Based Organization	186	6.3%
Other	185	6.2%
Other Client	84	2.8%
Social Service Agency	67	2.3%
Relative/ Friend	60	2.0%
Other Health Care Provider	59	2.0%
Other MICHC Program	46	1.6%
Pediatrician	44	1.5%
Mental Health/Behavioral Health	41	1.4%
Public Health Nurse / LHD	36	1.2%
Primary Care Physician	30	1.0%
Family Planning Provider	30	1.0%
Managed Care Plan	29	1.0%
School	28	0.9%
Insurance Navigator	26	0.9%
Health Home	20	0.7%
Faith-Based Organization	17	0.6%
Dental Provider	0	0.0%
Street Outreach	1,172	26.9%
Group Sessions	79	1.8%
Other Source	107	2.5%
Unrecorded	37	0.8%



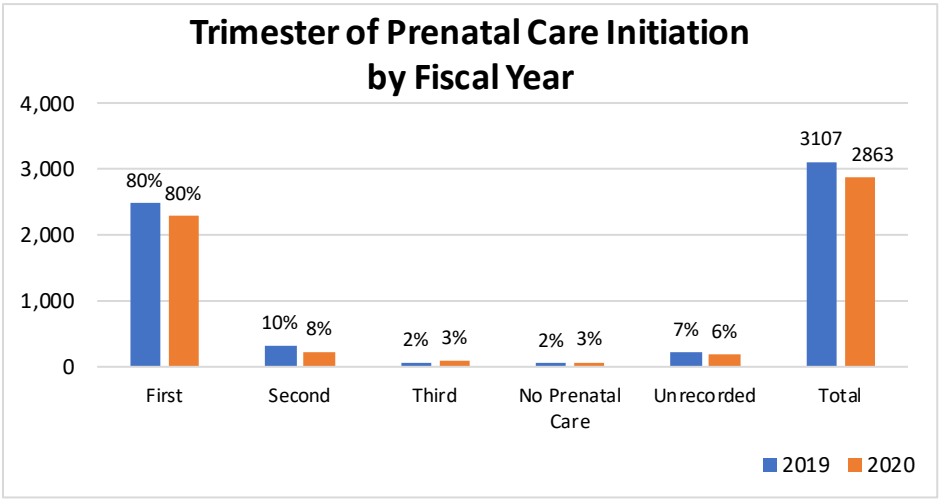
❖ Coronavirus Impact Analysis

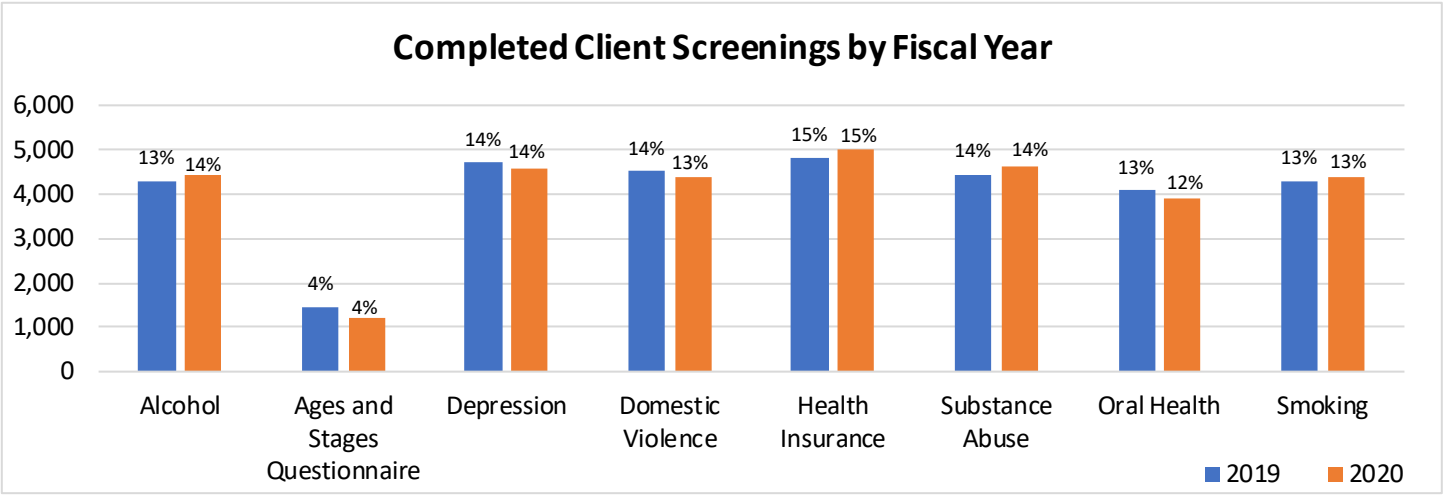
The Covid-19 pandemic disrupted services in the last half of the 2020 fiscal year. Visits with families continued through mostly virtual or remote methods. An analysis was completed to determine the impact on providing services to clients. Data on services in FY2020 were compared to pre-pandemic services in FY2019.

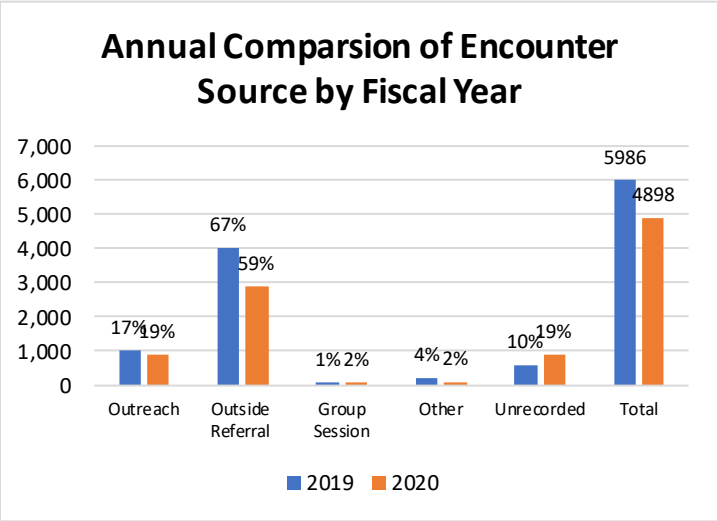




Results show that the pandemic did not prevent access to healthcare providers for MICHC clients. A higher proportion of post-partum clients attended their post-partum visit within the 8-week recommended period during FY2020 compared to FY2019. There were also slightly more preventative well-woman visits during FY2020. Prenatal care initiation and completed screenings were similar across both reporting periods.

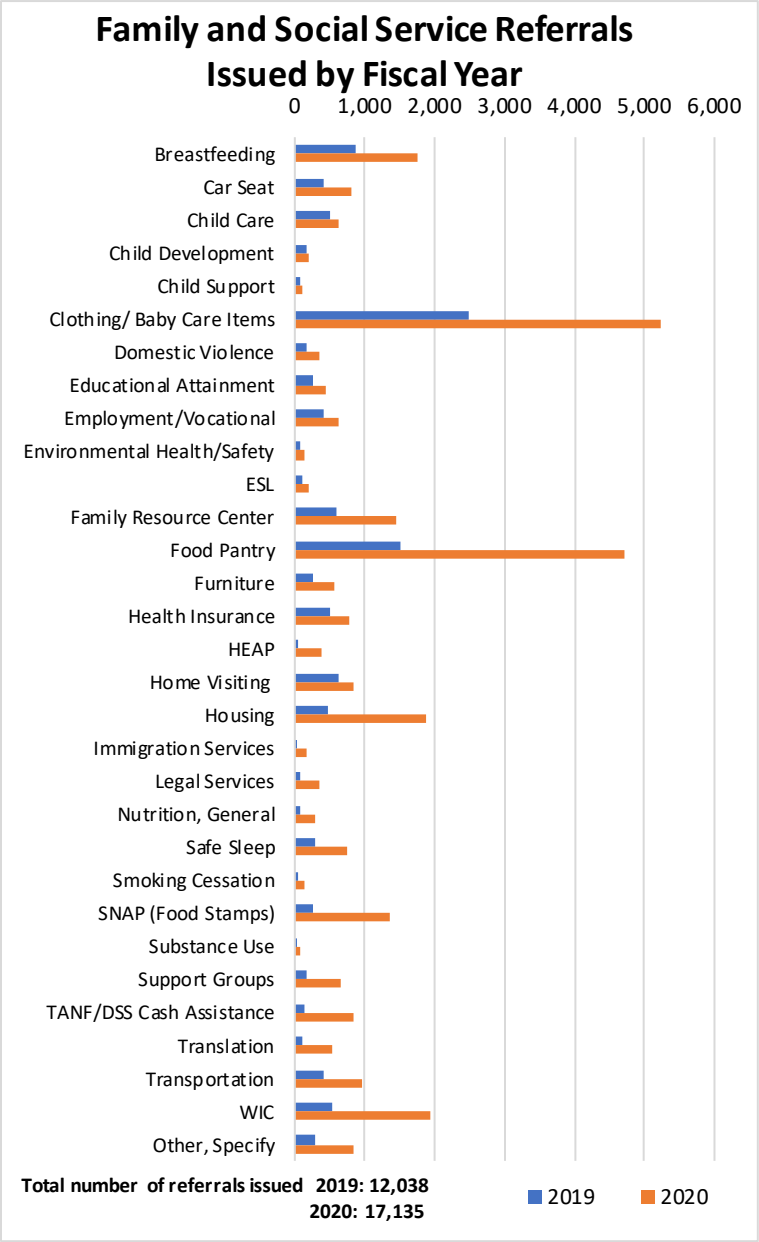






Overall, the biggest difference for FY2020 compared to FY2019 was the lower number of clients served and fewer referrals received from outside sources. This is consistent with qualitative data received from the programs. Referral sources were less likely to see clients in person, limiting opportunities to refer to MICHC. In addition, clients were often engaged in the MICHC program longer as needs increased during the pandemic and resources became scarce. CHWs reported that it was often hard to locate available services for clients as community needs increased. Visits per client increased as more frequent but shorter remote visits replaced in-person home visits.

Family and Social Service Referrals data demonstrated the increased need for concrete supports and services. Referrals to clothing and or baby care items more than doubled in FY2020 from 2,485 to 5,228; referrals to food pantries more than tripled from 1,518 in FY2019 to 4,707 in FY2020; and referrals to affordable housing more than quadrupled from 483 in FY2019 to 1,869 in FY2020. MICHC programs partnered with the New York State Department of Health (NYSDOH) and local diaper banks to provide access to diapers, wipes, formula, and other baby care items that were scarce at the onset of the pandemic. Referrals to SNAP, WIC, HEAP, and TANF also drastically increased during FY2020. As families struggled with job losses, loss of wages, remote schooling, and more time together at home, there were increases in positive screens for intimate partner violence and substance use, leading to increases in referrals to domestic violence and substance use services and homeless shelters.



Conclusions

MICHC programs across New York State serve a wide range of individuals and families in lower resourced communities by working diligently to provide outreach, assess needs, and find available supports and services including increased engagement with healthcare providers. The onset of the Coronavirus pandemic in early 2020 led to immediate changes in the need for and threatened disruption in services for New Yorkers – particularly those living in vulnerable communities served by MICHC programs. MICHC programs were able to swiftly adapt and adjust program operations to ensure services continued. Remote visits through telephone, video, and other virtual methods replaced in-person home visits to continue the work. As needs increased for families so did creative thinking, partnerships, and collaborations by MICHC programs to meet these needs. The existing networks and strong community partnerships built and sustained by MICHC programs were a valuable resource for New York families at the beginning of the pandemic. In the future, MICHC programs will continue to work to provide access to continuous quality healthcare, health insurance, and family and social services and supports.

FOR ALL YOUR AMAZING WORK AND DEDICATION

The Neighborhood Center, Inc.

Chautauqua County Health Department

Seal of the County of Albany 1683

REACH CNY
Resources, Education, Advocacy, and Collaboration for Health

NCPPC Every Woman, Every Child, Every Family
North Country Prenatal/Perinatal Council, Inc.

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Healthy Baby Network
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Niagara Falls Memorial Medical Center
Exceptional care, exceptionally close.

MiSN
Where Healthy Futures Start

The Institute for Family Health

CAMBA
where you can

CHCR
Community Health Center of Richmond

ECC

Suffolk County Seal New York

nmpp
Northern Manhattan Perinatal Partnership

Lower Hudson Valley Perinatal Network
Working Together for Healthy Communities

Public Health Solutions
Merging Research and Action

Wyckoff
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Orange County New York 1 November 1683

Urban Health Plan